



**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Harvoni Tablet/Pellet Pack/Ledipasvir-Sofosbuvir: Initial PA Request Form**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: 28 11. Length of Therapy (in days): ☒ 8 Weeks
(only 8 weeks can be approved with this form. Must use continuation form to request further treatment)

Clinical Information

Total length of therapy being requested (Check ONE):

- ☐ **8 weeks** = Genotype 1 - Treatment-naïve without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL
- ☐ **12 weeks** = Genotype 1, 4, 5, or 6 - Treatment-naïve and treatment-experienced without cirrhosis or with compensated cirrhosis (Child-Pugh A)
- ☐ **24 weeks** = Treatment-experienced with compensated cirrhosis (Child-Pugh A)
- ☐ **Harvoni + ribavirin 12 weeks** = Genotype 1 - Treatment-naïve and treatment-experienced with decompensated cirrhosis (Child-Pugh B or C) or Genotype 1 or 4 – Treatment-naïve and treatment-experienced liver transplant recipients without cirrhosis, or with compensated cirrhosis (Child-Pugh A)
1. Is the beneficiary 3 years or older w/ a diagnosis of Chronic Hepatitis C (CHC) infection w/ confirmed genotype 1, 4, 5 or 6 infection without cirrhosis or w/ compensated cirrhosis, or genotype 1 infection w/ decompensated cirrhosis, in combination w/ ribavirin; or genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or w/ compensated cirrhosis, in combination w/ ribavirin? ☐ **Yes** ☐ **No** **Genotype:** _____ **Fibrosis stage:** _____
2. Are medical records documenting the diagnosis of chronic hepatitis C with genotype and subtype attached? ☐ **Yes** ☐ **No** ****Lab test results MUST be attached to the PA to be approved.****
3. Which of the following are included with the submitted medical records to document the staging of liver disease:
☐ Metavir scores ☐ FibroSURE score ☐ IASL scores
☐ Batts-Ludwig scores ☐ Fibroscan score ☐ Ishak scores
☐ APRI score ☐ Radiological imaging consistent with cirrhosis
☐ Physical findings or clinical evidence consistent with cirrhosis as attested by the prescribing physician
4. Does the beneficiary have a documented quantitative HCV RNA at baseline that was tested within the past 6 months (medical documentation required)? ☐ **Yes** ☐ **No** **HCV RNA (IU/ml):** _____ and/or **log10 value** _____
5. Will Harvoni be used in combination with amiodarone? ☐ **Yes** ☐ **No**
6. Will Harvoni be used in combination with other drugs containing sofosbuvir? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.